STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 657-2941

January 3, 2002

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Health Executives
All County Mental Health Directors

Letter No.: 02-02

CAMERA-READY COPIES OF NOTICES OF ACTION AFFECTED BY SENATE BILL(SB) 87

Ref.: All County Welfare Directors Letter (ACWDL) Nos. 99-05, 99-44, 01-17, 01-33, and 01- 53

This letter contains new and revised camera-ready copies of the Medi-Cal Notices of Action (NOA) as required by SB 87 (Chapter 1088 Statues of 2000).

The following NOAs are enclosed:

1. MC 239 TMC-2 Transitional Medi-Cal (TMC) Denial or Discontinuance - Revised

2. MC 239 TMC-2 (SP) TMC Denial or Discontinuance-Revised

3. MC 357 Draft - Four Month Continuing Program Denial or Discontinuance of Benefits - New

The Four Month Continuing Program Denial or Discontinuance NOA is only available in draft; however, counties may use the sample language if needed until the camera-ready copy is sent in a future ACWDL.

If you have any further questions, please contact Ms. Margie Buzdas of my staff at (916) 657-0726.

Sincerely,

ORIGINAL SIGNED BY

Richard Brantingham
Acting Chief
Medi-Cal Eligibility Branch

Enclosures

MEDI-CAL
NOTICE OF ACTION
Transitional Medi-Cal (TMC)
Denial or Discontinuance of Benefits

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

☐ Your benefits under TMC will be discontinued effective the last day of _____.

☐ Eligibility for benefits under the initial TMC program ends _____ because:

- ☐ There is no longer a child in the home.
- ☐ Other: _____

☐ Eligibility for benefits for the additional or second-year TMC program ends because:

- ☐ There is no longer a child in the home.
- ☐ You failed to return a completed status report.
- ☐ Your family's gross average earnings (less child care costs) exceed the limit.
- ☐ The caretaker relative or principal wage earner is no longer employed.
- ☐ Other: _____

☐ You are not eligible for:

- ☐ Initial TMC
- ☐ Additional TMC
- ☐ Second Year TMC
- ☐ Any other Medi-Cal program

Here is the reason: _____

☐ You will receive a separate notice about your eligibility for the regular Medi-Cal program.

DO NOT THROW AWAY YOUR PLASTIC ID CARD. You can use it again if you become eligible for Medi-Cal.

The regulation which requires this action is California Code of Regulations, Title 22, Section 50244.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL

Medi-Cal de Transición *(TMC)*

Negación o Descontinuación de Beneficios

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____

Nombre del trabajador: _____

Número del trabajador: _____

Número de teléfono del trabajador: _____

Horario de la oficina: _____

Notificación para: _____

☐ Sus beneficios bajo el *TMC* se descontinuarán a partir del último día de _____.

☐ La elegibilidad para recibir beneficios bajo el programa inicial del *TMC* termina _____ porque:

- ☐ Ya no vive un(a) niño(a) en el hogar.
- ☐ Otro: _____

☐ La elegibilidad para recibir beneficios adicionales o durante el segundo año del programa de *TMC* termina _____ porque:

- ☐ Ya no vive un(a) niño(a) en el hogar.
- ☐ Usted no regresó un reporte completado sobre la situación.
- ☐ Los ingresos brutos promedio de su familia (menos los costos del cuidado de niños) exceden el límite.
- ☐ El pariente encargado del cuidado o el proveedor principal ya no trabaja.
- ☐ Otro: _____

☐ Usted no reúne los requisitos para recibir beneficios:

- ☐ *TMC* inicial
- ☐ Adicionales del *TMC*
- ☐ Del Segundo Año del *TMC*
- ☐ De cualquier otro programa de Medi-Cal

La razón es la siguiente: _____

☐ Usted recibirá una notificación por separado sobre su elegibilidad para el programa regular de Medi-Cal.

NO TIRE SU TARJETA DE IDENTIFICACIÓN DE PLÁSTICO. Usted puede usarla nuevamente si vuelve a reunir los requisitos para recibir beneficios de Medi-Cal.

La regulación que exige esta acción es la Sección 50244, del Título 22, del Código de Regulaciones de California.

MEDI-CAL
NOTICE OF ACTION
FOUR-MONTH CONTINUING PROGRAM
DENIAL OR DISCONTINUANCE OF BENEFITS

(COUNTY STAMP)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

The Four-Month Continuing Medi-Cal program is for families who were discontinued from CalWORKs or Section 1931(b) Medi-Cal due to an increase or receipt of child or spousal support payments.

☐ Your benefits under the Four-Month Continuing program will be discontinued effective the last day of _____.

☐ You are not eligible for the Four-Month Continuing program.

Here is/are the reasons(s) why:

☐ You do not have an eligible child living in the home.

☐ Your only eligible child is over the age limit.

☐ You did not receive CalWORKs or Section 1931(b) in three of the last six months.

☐ You moved out of California.

☐ Other: _____

_____

You will receive another notice if you are eligible for another Medi-Cal program.

DO NOT THROW AWAY YOUR PLASTIC BENEFITS IDENTIFICATION CARD (BIC). You can use it again if you become eligible or are eligible for another Medi-Cal program.

The regulation that requires this action is California Code of Regulations, Title 22, Section 50243.